## Health History Form



Today's Date:



American Dental Association www.ada.org

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: 1	Include area code	Business/Cell Phone	: Include area code	
Last	First	Middle	( )		( )		
Address:			City:		State:	Zip:	
Mailing address							
Occupation:			Height:	Weight:	Date of birth:	Sex: M F	
SS# or Patient ID:	Emergency Contact:		Relationship:		Home Phone:	Cell Phone:	
					( ) Include area codes	( )	
If you are completing this form for another person, what is your relationship to that person?							
Your Name			Relationship				
Do you have any of the following diseases or problems:			(Check DK if you Don't Know the answer to the question) Yes No DK				
Active Tuberculosis						🗆 🗆 🗆	
Persistent cough greater than a 3 w	veek duration						
Cough that produces blood						🗆 🗆 🗆	
Been exposed to anyone with tube	rculosis						

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

## Dental Information For the following questions, please mark (X) your responses to the following questions.

Yes No DK	Yes No DK	
Do your gums bleed when you brush or floss?	Do you have earaches or neck pains?	
Are your teeth sensitive to cold, hot, sweets or pressure? $\Box$ $\Box$	Do you have any clicking, popping or discomfort in the jaw? $\Box$ $\Box$	
Does food or floss catch between your teeth? $\Box$ $\Box$	Do you brux or grind your teeth?	
Is your mouth dry? $\Box$ $\Box$	Do you have sores or ulcers in your mouth?	
Have you had any periodontal (gum) treatments?	Do you wear dentures or partials?	
Have you ever had orthodontic (braces) treatment?	Do you participate in active recreational activities? $\Box$ $\Box$	
Have you had any problems associated with previous dental	Have you ever had a serious injury to your head or mouth? $\Box$ $\Box$	
treatment?	Date of your last dental exam:	
Is your home water supply fluoridated?	What was done at that time?	
Do you drink bottled or filtered water?		
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	Date of last dental x-rays:	
Are you currently experiencing dental pain or discomfort?	······································	
What is the reason for your dental visit today?		

How do you feel about your smile?

## Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes No DK	Yes	No	DK
Are you now under the care of a physician?	□ □ □	Have you had a serious illness, operation or been		
Physician Name:	Phone: Include area code	hospitalized in the past 5 years?		
( )		If yes, what was the illness or problem?		-
Address/City/State/Zip:				
		Are you taking or have you recently taken any prescription		
Are you in good health?	□ □ □	or over the counter medicine(s)?		
Has there been any change in your general health $w$		If so, please list all, including vitamins, natural or herbal preparations		
the past year?		and/or diet supplements:		
If yes, what condition is being treated?				
Date of last physical exam:				
				_

## Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Do you wear contact lenses?		No	DK	Yes         No         DK           Do you use controlled substances (drugs)?         □         □	( 		
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?				Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	. 🗆			Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? If yes, how much do you typically drink In a week?			
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal				WOMEN ONLY       Are you:         Pregnant?       Image: Ima			
complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	. 🗆			Taking birth control pills or hormonal replacement? <ul> <li>Image: Image: Im</li></ul>			
	Vee	N		Ver Ne Di	,		
<b>Allergies</b> - Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.	Yes	No	DK	Yes     No     DK       Metals	i. I		
Local anesthetics				Latex (rubber) □ □ □	1		
Aspirin				lodine			
Penicillin or other antibiotics				Hay fever/seasonal			
Barbiturates, sedatives, or sleeping pills				Animals			
Sulfa drugs				Food □ □ □	J		
Codeine or other narcotics				Other	I.		
Please mark (X) your response to indicate if you have or have not					-		
		No	DK	Yes No DK Yes No DK	(		
Artificial (prosthetic) heart valve				Autoimmune disease			
Previous infective endocarditis				Rheumatoid arthritis			
Damaged valves in transplanted heart	·· 🗆			Systemic lupus erythematosus.			
Congenital heart disease (CHD)				Asthma			
Unrepaired, cyanotic CHD Repaired (completely) in last 6 months				Bronchitis       Image: Construction of the second seco			
Repaired CHD with residual defects				Sinus trouble			
				Tuberculosis       Image: Comparison of the second se			
Except for the conditions listed above, antibiotic prophylaxis is no longer record for any other form of CHD.	omme	endec	d	Cancer/Chemotherapy/       Specify:         Radiation Treatment			
Yes No DK	Yes	No	DK		-		
Cardiovascular disease	🗆			Chronic pain	I.		
Angina				Diabetes Type I or II			
Arteriosclerosis				Eating disorder			
Congestive heart failure				Malnutrition			
Damaged heart valves				Gastrointestinal disease			
Heart attack				G.E. Reflux/persistent Severe headaches/	1		
Heart murmur	_			heartburn			
Low blood pressure				Ulcers       Severe or rapid weight loss         Thyroid problems       Sexually transmitted disease			
High blood pressure       Image: Hemophilia         Other congenital heart       AIDS or HIV infection				Stroke			
defects							
	🗆						
	ibiot	ics p	rior	to your dental treatment? □ □ □			
Name of physician or dentist making recommendation:				Phone:			
Do you have any disease, condition, or problem not listed above the Please explain:	at yc	u th	ink I	should know about?			
<b>NOTE:</b> Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.							
Signature of Patient/Legal Guardian:				Date:			
FOR	<u> </u>	MD:	ET'	ON BY DENTIST	=		
	CU	IVI PL					
Comments:							